



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Amy Kirsch, D.C.

**Respondent Name**

Commerce & Industry Insurance Company

**MFDR Tracking Number**

M4-17-3066-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 16, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "99456 W5 WP MMI = 350.00

Shoulder IR w/ ROM = 300.00

Spine IR = 150.00

Total Paid = 350.00

99456 W5 MI Pays 50.00 Per Additional IR

Total Balance Due = 500.00"

**Amount in Dispute:** \$500.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The Carrier initially paid \$350 on 9/8/16 for CPT code(s) 99456 W5 WP and 99456 W5 MI. After further review, the Carrier reimbursed the Provider an additional \$350. For procedure code 99456 W5 WP, the carrier reimbursed the Provider an additional \$300 and, for procedure code 99456 W5 MI, \$50 is being reimbursed."

**Response Submitted by:** AIG

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2016	Designated Doctor Examination	\$500.00	\$150.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services performed

from March 1, 2008, until September 1, 2016.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - Workers' compensation jurisdictional fee schedule adjustment.
  - The charge for the procedure exceeds the amount indicated in the fee schedule.
  - The reported modifier is not valid for the procedure code or service.

### **Issues**

1. Did the insurance carrier maintain a denial of procedure 99456-W5-MI?
2. Is Amy Kirsch, D.C. entitled to additional reimbursement?

### **Findings**

1. Commerce & Industry Insurance Company denied procedure code 99456-W5-MI stating, "The reported modifier is not valid for the procedure code or service." Review of the submitted documentation finds that Commerce & Industry Insurance Company did not maintain its denial of this procedure code in its response. Therefore, this denial will not be considered.
2. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that Dr. Kirsch performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204(j)(4),

The following applies for billing and reimbursement of an IR evaluation ...

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows...

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area.

(-b-) \$150 for each additional musculoskeletal body area.

The submitted documentation indicates that Dr. Kirsch provided an impairment rating and performed a full physical evaluation with range of motion for the cervical spine and left shoulder. Therefore, the MAR for this examination is \$450.00.

28 Texas Administrative Code §134.204 (j)(4)(B) states,

When multiple IRs are required as a component of a designated doctor examination ... the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

The submitted documentation indicates that Dr. Kirsch was ordered to address maximum medical improvement, impairment rating, and extent of injury. The narrative report and enclosed forms support that these examinations were performed, and one additional impairment rating was provided. Therefore, the correct MAR for this service is \$50.00.

The total MAR for the disputed services is \$850.00. The Commerce & Industry Insurance Company reimbursed a total of \$700.00. An additional reimbursement of \$150.00 is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

### **ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

#### **Authorized Signature**

_____	Laurie Garnes	August 8, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**